# CHAPTER 6: MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM (SNF PPS)

## 6.1 Background

The Balanced Budget Act of 1997 included the implementation of a Medicare Prospective Payment System (PPS) for skilled nursing facilities, consolidated billing, and a number of related changes. The PPS system replaces the retrospective cost-based system for skilled nursing facilities under Part A of the program. (Federal Register Vol. 63, No. 91, May 12, 1998, Final Rule.)

The SNF PPS is the culmination of substantial research efforts beginning as early as the 1970's, focusing on the areas of nursing facility payment and quality. In addition, it is based on a foundation of knowledge and work by a number of states that developed and implemented similar case mix payment methodologies for their Medicaid nursing facility payment systems.

The current focus in the development of State and Federal payment systems for nursing facility care is based on the recognition of the differences among residents, particularly in the utilization of resources. Some residents require total assistance with their activities of daily living (ADLs) and have complex nursing care needs. Other residents may require less assistance with ADLs, but may require rehabilitation or restorative nursing services. The recognition of these differences is the premise of a case mix system. Reimbursement levels differ based on the resource needs of the residents. Residents with heavy care needs require more staff resources and payment levels would be higher than for those residents with less intensive care needs. In a case mix adjusted payment system the amount of reimbursement to the nursing facility is based on the resource intensity of the resident as measured by items on the MDS. Case mix reimbursement has become a widely adopted method for financing nursing facility care. The case mix approach serves as the basis for the PPS for skilled nursing facilities, swing bed hospitals and is increasingly being used by States for Medicaid reimbursement for nursing facilities.

## 6.2 Utilizing the MDS in the Medicare Prospective Payment System

A key component of the Medicare skilled nursing facility prospective payment system is the case mix reimbursement methodology used to determine resident care needs. A number of nursing facility case mix systems have been developed over the last 20 years. Since the early 1990's, however, the most widely adopted approach to case mix has been the Resource Utilization Groups (RUG-III). This classification system uses information from the MDS assessment to classify SNF residents into a series of groups representing the residents' relative direct care resource requirements.

The MDS assessment data is used to calculate the RUG-III Classification necessary for payment. The MDS contains extensive information on the resident's nursing needs, ADL impairments, cognitive status, behavioral problems, and medical diagnoses. This information is used to define RUG-III groups that form a hierarchy from the greatest to the least resources used. Residents with more specialized nursing requirements, licensed therapies, greater ADL dependency or other conditions will be assigned to higher groups in the RUG-III hierarchy. Providing care to these residents is more costly, and is reimbursed on a higher level.

## 6.3 Resource Utilization Groups Version III (RUG-III)

The RUG-III classification system has seven major classification groups: Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Function. The seven groups are further divided by the intensity of the resident's activities of daily living (ADL) needs, and in the Clinically Complex category, by the presence of depression.

One hundred and eight (108) MDS assessment items are used in the RUG-III Classification system to evaluate the resident's clinical condition.

A calculation worksheet was developed in order to provide clinical staff with a better understanding of how the RUG-III classification system works. The worksheet translates the software programming into plain language to assist staff in understanding the logic behind the classification system. A copy of the calculation worksheet for the RUG-III Classification system for nursing facilities can be found at the end of this section.

| SEVEN MAJOR RUG-III CLASSIFICATION GROUPS | |
|---|---|
| **MAJOR RUG-III GROUP** | **CHARACTERISTICS ASSOCIATED WITH MAJOR RUG-III GROUP** |
| Rehabilitation | Residents receiving physical, speech or occupational therapy. |
| Extensive Services | Residents receiving complex clinical care or with complex clinical needs such as IV feeding or medications suctioning, tracheostomy care, ventilator/respirator and comorbidities that make the resident eligible for other RUG categories. |
| Special Care | Residents receiving complex clinical care or with serious medical conditions such as multiple sclerosis, quadriplegia, cerebral palsy, respiratory therapy, ulcers, stage III or IV pressure ulcers, radiation, surgical wounds or open lesions, tube feeding and aphasia, fever with dehydration, pneumonia, vomiting, weight loss or tube feeding. |
| Clinically Complex | Residents receiving complex clinical care or with conditions requiring skilled nursing management and interventions for conditions and treatments such as burns, coma, septicemia, pneumonia, foot/wounds, internal bleeding, dehydration, tube feeding, oxygen, transfusions, hemiplegia, chemotherapy, dialysis, physician visits/order changes. |
| Impaired Cognition | Residents having cognitive impairment in decision-making, recall and short-term memory. (Score on MDS 2.0 cognitive performance scale >=3). |
| Behavior Problems | Residents displaying behavior such as wandering, verbally or physically abusive or socially inappropriate, or who experience hallucinations or delusions |
| Reduced Physical Functions | Residents whose needs are primarily for activities of daily living and general supervision. |

## 6.4 Relationship Between the Assessment and the Claim

The SNF PPS establishes a schedule of Medicare assessments. Each required Medicare assessment is used to support Medicare PPS reimbursement for a predetermined **maximum** number of Medicare Part A days. To verify that the Medicare bill accurately reflects the assessment information, three data items derived from the MDS assessment must be included on the Medicare claim:

### 1. ASSESSMENT REFERENCE DATE (ARD)

The ARD must be reported on the Medicare claim. If no MDS assessment was completed, the ARD is not used and the claim must be billed at the default rate. CMS has developed mechanisms to link the assessment and billing records.

### 2. THE RUG-III GROUP

The RUG-III group is calculated from the MDS assessment data. The software used to encode and transmit the MDS assessment data calculates the RUG-III group. CMS edits and validates the RUG-III code of transmitted MDS assessments. Facilities cannot submit Medicare Part A claims until the assessment has been accepted into the CMS data base, and they must use the RUG-III code as validated by CMS when bills are filed. The following abbreviated RUG-III codes are used in the billing process.

RUA, RUB, RUC, RVA, RVB, RVC, RHA, RHB, RHC, RMA, RMB, RMC, RLA, RLB
SE1, SE2, SE3
SSA, SSB, SSC
CA1, CA2, CB1, CB2, CC1, CC2
IA1, IA2, IB1, IB2
BA1, BA2, BB1, BB2
PA1, PA2, PB1, PB2, PC1, PC2, PD1, PD2, PE1, PE2
AAA (the default code)

### 3. HEALTH INSURANCE PPS (HIPPS) CODES

Each Medicare PPS assessment is used to support Medicare Part A payment for a maximum number of days. The HIPPS code, also known as an Assessment Indicator, must be entered on each claim, and must accurately reflect which assessment is being used to bill the RUG-III group for Medicare reimbursement.

The CMS HIPPS codes contain a three position code to represent the RUG-III of the SNF resident, plus a 2-position assessment indicator to indicate which assessment was completed. Together they make up the 5-position HIPPS code for the purpose of billing

Part A covered days to the Fiscal Intermediary. The charts shown below list the HIPPS codes used by SNFs.

HIPPS codes have been established for each type of assessment used to support Medicare payment. For example, the Medicare reason for assessment on a Medicare 5-Day assessment is "1", and the HIPPS code is "01".

Under the SNF PPS, there are situations when two assessments may be needed to fulfill Medicare requirements. Rather than requiring such duplication of effort, providers have the ability to combine assessments (see Chapter 2 for more detailed information). For example, if an OMRA is required during the assessment window for a Medicare 30-Day assessment (i.e., days 21-34), the SNF is required to perform only one assessment. There is no way to code two Medicare Reasons for Assessment. The combined OMRA/30-Day Medicare assessment is coded on the MDS as an OMRA and identified on the Part A billing by using a HIPPS code of "28". The combined assessment can then be used when billing the Medicare claim. Similarly, if an assessment is a combined OMRA/30-Day and an SCSA, the SCSA is coded as the primary Reason for Assessment. The OMRA is shown as the Medicare Reason for Assessment, and the HIPPS code used for billing is 28.

In addition, 5 new codes have been established for special payment situations. More specific information on the use of these billing codes will be issued in early 2003.

## SNF HIPPS MODIFIERS/ASSESSMENT TYPE INDICATORS

| | |
|---|---|
| 01 | 5-Day Medicare-required assessment/not an Admission assessment. |
| 02 | 30-Day Medicare-required assessment. |
| 03 | 60-Day Medicare-required assessment. |
| 04 | 90-Day Medicare-required assessment. |
| 05 | Readmission/Return Medicare-required assessment. |
| 07 | 14-Day Medicare-required assessment/not an Admission assessment. |
| 08 | Off-cycle Other Medicare-required assessment (OMRA). |
| 11 | 5-Day (or readmission/return) Medicare-required assessment AND Admission assessment. |
| 17 | 14-Day Medicare-required assessment AND Admission assessment: This code is being activated to facilitate the planned automated generation of all assessment indicator codes. Currently, code 07 is used for all 14-Day Medicare assessments, regardless of whether it is also an OBRA Admission assessment (i.e., an assessment mandated as part of the Medicare/Medicaid certification process). |
| 18 | OMRA (Other Medicare Required Assessment) replacing 5-Day Medicare-required assessment |

| | |
|---|---|
| 19 | Special payment situation – 5-Day assessment |
| 28 | OMRA replacing 30-Day Medicare-required assessment |
| 29 | Special payment situation – 30-Day assessment |
| 30 | Off-cycle Significant Change assessment (outside assessment window). |
| 31 | Significant Change assessment REPLACES 5-Day Medicare-required assessment. |
| 32 | Significant Change assessment (SCSA) REPLACES 30-Day Medicare-required assessment |
| 33 | Significant Change assessment REPLACES 60-Day Medicare-required assessment |
| 34 | Significant Change assessment REPLACES 90-Day Medicare-required assessment |
| 35 | Significant Change assessment REPLACES a readmission/return Medicare-required assessment. |
| 37 | Significant Change assessment REPLACES 14-Day Medicare-required assessment |
| 38 | OMRA replacing 60-Day Medicare-required assessment. |
| 39 | Special payment situation – 60-Day assessment. |
| 40 | Off-cycle Significant Correction assessment of a prior assessment (outside assessment window) |
| 41 | Significant Correction of a Prior assessment (SCPA) REPLACES a 5-Day Medicare-required assessment |
| 42 | Significant Correction of a Prior assessment REPLACES 30-Day Medicare-required assessment |
| 43 | Significant Correction of a Prior assessment REPLACES 60-Day Medicare-required assessment |
| 44 | Significant Correction of a Prior assessment REPLACES 90-Day Medicare-required assessment |
| 45 | Significant Correction of a Prior assessment REPLACES a readmission/return assessment. |
| 47 | Significant Correction of a Prior assessment REPLACES 14-Day Medicare-required assessment |
| 48 | OMRA replacing 90-Day Medicare required assessment. |
| 49 | Special payment situation – 90-Day assessment. |
| 54 | 90-Day Medicare assessment that is also a Quarterly assessment |
| 78 | OMRA replacing 14-Day Medicare-required assessment. |
| 79 | Special payment situation – 14-Day assessment |
| 00 | Default code |

## 6.5 SNF PPS Eligibility Criteria for SNFs

Under SNF PPS, beneficiaries must meet the established eligibility requirements for a Part A SNF-level stay. These requirements are summarized below.

### TECHNICAL ELIGIBILITY REQUIREMENTS

Technical eligibility remains the same, as outlined below, per the Medicare Intermediary Manual, Claims Process, Part 3 (HCFA Pub. 13-3) and the Skilled Nursing Facility Manual (HCFA Pub. 12). The beneficiary must meet the following criteria:

- Beneficiary is Enrolled in Medicare Part A and has days available to use.
- There has been a three-day prior qualifying hospital stay.
- Admission for SNF-level services is within thirty days of discharge from an acute care stay.

  **NOTE:** See CMS Pub 13-3 Section 3131.3B for an exception to the 30-day transfer requirement; i.e., Medical Appropriateness Exception.

### CLINICAL ELIGIBILITY REQUIREMENTS

A beneficiary is eligible for SNF extended care if all the following requirements are met:

- The beneficiary has a need for and receives medically necessary skilled care on a daily basis, which is provided by or under the direct supervision of skilled nursing or rehabilitation professionals.
- As a practical matter, these skilled services can only be provided in an SNF.
- The services provided must be for a condition for which the resident:
  - -- was treated during the qualifying hospital stay, or
  - -- arose while the resident was in the SNF for treatment of a condition for which he/she was previously treated for in a hospital.

### PHYSICIAN CERTIFICATION

A physician, or a clinical nurse specialist, or nurse practitioner employed by a physician (and not employed by the SNF) must certify and then periodically re-certify the need for extended care services in the nursing facility.

- **Certifications** are required at the time of admission or as soon thereafter as is reasonable and practicable. (42 CFR 424.20)

  -- The initial certification certifies, per the existing context found in 42 CFR 424.20, that the resident meets the existing SNF level of care definition, **or**

  -- Validates that the beneficiary's assignment to one of the upper RUG-III (Top 26) groups is correct through a statement indicating the assignment is correct.

- **Re-certifications** are used to document the continued need for skilled extended care services.

  -- The first re-certification is required no later than the **14th** day.

  -- Subsequent re-certifications are required no later than **30 days** after the first re-certification.

  **NOTE:** These certification statements have no correlation to requirements specifically related to the plan of treatment for therapy that is required for purposes of coverage.

## 6.6 RUG-III 44 Group Model Calculation Worksheet for SNFs

This RUG-III Version 5.12 calculation worksheet is a step-by-step walk through to manually determine the appropriate RUG-III Classification based on the information from an MDS assessment. The worksheet takes the computer programming and puts it into words. We have carefully reviewed the worksheet to insure that it represents the standard logic.

This worksheet is for the 44-group RUG-III Version 5.12 model. In the 44-group model, there are 14 different Rehabilitation groups representing 5 different levels of rehabilitation services. The 44-group model is therefore well suited for use with restorative programs that classify residents on the basis of both nursing care needs and rehabilitation needs. The Medicare PPS program is a good example of such a program. RUG-III models order the groups from high to low resource need. In the 44-group model, the residents in the Rehabilitation groups have the highest level of combined nursing and rehabilitation need, while residents in the Extensive Services groups have the next highest level of need. Therefore, the 44-group model has the Rehabilitation groups first followed by the Extensive Services groups, the Special Care groups, the Clinically Complex groups, the Impaired Cognition groups, the Behavior Problems groups, and finally the Reduced Physical Functions groups.

There are two basic approaches to RUG-III Classification: (1) hierarchical classification and (2) index maximizing classification. CMS has not developed an index maximization worksheet. The worksheet included at the end of this chapter was developed for the hierarchical methodology. Instructions for adapting this worksheet to the index maximizing approach are included below.

**Hierarchical Classification.** The present worksheet employs the hierarchical classification method. Hierarchical classification is used in some payment systems, in staffing analysis, and in many research projects. In the hierarchical approach, you start at the top and work down through the RUG-III model, and the classification is the first group for which the resident qualifies. In other words, start with the Rehabilitation groups at the top of the RUG-III model. Then you work your way down through the groups in hierarchical order: Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavior Problems, and Reduced Physical Functions. When you find the first of the 44 individual RUG-III groups for which the resident qualifies, then assign that group as the RUG-III Classification and you are finished.

If the resident would qualify in one of the Rehabilitation groups and also in a Extensive Services group, always choose the Rehabilitation classification, since it is higher in the hierarchy. Likewise, if the resident qualifies for Special Care and Clinically Complex, always choose Special Care. In hierarchical classification, always pick the group nearer the top of the model.

**Index Maximizing Classification.** Index maximizing classification is used in Medicare PPS and most Medicaid payment systems. For a specific payment system, there will be a designated set of Case Mix Indices (CMI) for each RUG-III group. The first step in index maximizing is to determine all of the RUG-III groups for which the resident qualifies. Then from the qualifying groups you choose the RUG-III group that has the highest case mix index. Index maximizing classification is simply choosing the group with the highest index. The index maximizing method uses the case mix indices prior established in July 1998 when the SNF PPS was introduced. It does not reflect payment rate changes resulting from Congressionally mandated "add-on" payments.

While the present worksheet illustrates the hierarchical classification method, it can be adapted for index maximizing. To index maximize, you would evaluate all classification groups rather than assigning the resident to the first qualifying group. In the index maximizing approach, you again start at the beginning of the worksheet. You then work down through all of the 44 RUG-III Classification groups, ignoring instructions to skip groups and noting each group for which the resident qualifies. When you finish, record the CMI for each of these groups. Select the group with the highest CMI. This group is the index-maximized classification for the resident.

# *CALCULATION OF TOTAL "ADL" SCORE*
## *RUG-III, 44 GROUP HIERARCHICAL CLASSIFICATION*

The ADL score is used in all determinations of a resident's placement in a RUG-III category. It is a very important component of the classification process.

### ► *STEP # 1*

To calculate the ADL score use the following chart for G1a (bed mobility), G1b (transfer), and G1i (toilet use). **Enter the ADL scores to the right.**

| ***Column A =*** | | ***Column B =*** | ***ADL score =*** | ***SCORE*** |
|---|---|---|---|---|
| -, 0 or 1 | **and** | (any number) | = 1 | G1a=____ |
| 2 | **and** | (any number) | = 3 | G1b=____ |
| 3, 4, or 8 | **and** | -, 0, 1 or 2 | = 4 | G1i= ____ |
| 3, 4, or 8 | **and** | 3 or 8 | = 5 | |

### ► *STEP # 2*

If K5a (parenteral/IV) is checked, the eating ADL score is 3. If K5b (feeding tube) is checked and EITHER (1) K6a is 51% or more calories OR (2) K6a is 26% to 50% calories and K6b is 501cc or more per day fluid enteral intake, then the eating ADL score is 3**. Enter the ADL eating score (G1h) below and total the ADL score. If not, *go to Step #3.***

### ► *STEP # 3*

If neither K5a nor K5b (with appropriate intake) are checked, evaluate the chart below for G1hA (eating self-performance). *Enter the score to the right* and total the ADL score. This is the RUG-III **TOTAL ADL SCORE.** (The total ADL score range possibilities are 4 through 18.)

| ***Column A (G1h) =*** | ***ADL score =*** | ***EATING SCORE*** |
|---|---|---|
| -, 0 or 1 | = 1 | G1h =____ |
| 2 | = 2 | |
| 3, 4, or 8 | = 3 | |

**TOTAL RUG-III ADL SCORE** _____

*Other ADLs are also very important, but the researchers have determined that the late loss ADLs were more predictive of resource use. They determined that allowing for the early loss ADLs did not significantly change the classification hierarchy or add to the variance explanation.*

# *CATEGORY I: REHABILITATION*
## *RUG-III, 44 GROUP HIERARCHICAL CLASSIFICATION*

After determining a resident's total ADL score, you start the classification process beginning at the Rehabilitation level. Rehabilitation therapy is any combination of the disciplines of physical, occupational, or speech therapy. This information is found in Section P1b. Nursing rehabilitation is also considered for the low intensity classification level. It consists of providing active or passive range of motion, splint/brace assistance, training in transfer, training in dressing/grooming, training in eating/swallowing, training in bed mobility or walking, training in communication, amputation/prosthesis care, any scheduled toileting program, and bladder retraining program. This information is found in Section P3 and H3a,b of the MDS Version 2.0.

### ► *STEP # 1*

Determine if the resident's rehabilitation therapy services satisfy the criteria for one of the RUG-III Rehabilitation groups. **If the resident does not meet all of the criteria for one Rehabilitation group (e.g., Ultra High Intensity), then move to the next group (e.g., Very High Intensity).**

A. **Ultra High Intensity Criteria**

In the last 7 days (section P1b [a,b,c]):

720 minutes or more (total) of therapy per week **AND**
At least two disciplines, 1 for at least 5 days, **AND**
2nd for at least 3 days

| ***RUG-III ADL Score*** | ***RUG-III Class*** |
|---|---|
| 16 - 18 | RUC |
| 9 - 15 | RUB |
| 4 - 8 | RUA |

B. **Very High Intensity Criteria**

In the last 7 days (section P1b [a, b, c,]):

500 minutes or more (total) of therapy per week **AND**
At least 1 discipline for at least 5 days

| ***RUG-III ADL Score*** | ***RUG-III Class*** |
|---|---|
| 16 - 18 | RVC |
| 9 - 15 | RVB |
| 4 - 8 | RVA |

C. **High Intensity Criteria** (either (1) or (2) below may qualify)

(1) In the last 7 days (section P1b [a, b, c]):
325 minutes or more (total) of therapy per week **AND**
At least 1 discipline for at least 5 days

(2) **If this is a Medicare 5-Day or a Medicare Readmission/Return Assessment, then the following apply** (section T1b, T1c, T1d and section P1b [a, b, c]):
Ordered Therapies, T1b is checked **AND**
In the last 7 days:
Received 65 or more minutes, P1b [a,b,c] **AND**
In the first 15 days from admission:
520 or more minutes expected, T1d **AND**
rehabilitation services expected on 8 or more days, T1c.

| ***RUG-III ADL Score*** | ***RUG-III Class*** |
|---|---|
| 13 - 18 | RHC |
| 8 - 12 | RHB |
| 4 - 7 | RHA |

D. **Medium Intensity Criteria** (either (1) or (2) below may qualify)

(1) In the last 7 days: (section P1b [a,b,c] )
150 minutes or more (total) of therapy per week **AND**
At least 5 days of any combination of the 3 disciplines

(2) **If this is a Medicare 5-Day or a Medicare Readmission/Return Assessment, then the following apply:** (section T1b, T1c, T1d):
Ordered Therapies, T1b is checked **AND**
In the first 15 days from admission:
240 or more minutes are expected, T1d **AND**
rehabilitation services expected on 8 or more days, T1c.

| ***RUG-III ADL Score*** | ***RUG-III Class*** |
|---|---|
| 15 - 18 | RMC |
| 8 - 14 | RMB |
| 4 - 7 | RMA |

E. **Low Intensity Criteria** (either (1) or (2) below may qualify):

(1) In the last 7 days (section P1b [a,b,c] and P3):
45 minutes or more (total) of therapy per week **AND**
At least 3 days of any combination of the 3 disciplines **AND**
2 or more nursing rehabilitation services* received for at least 15 minutes each with each administered for 6 or more days.

(2) **If this is a Medicare 5-Day or a Medicare Readmission/Return Assessment, then the following apply** (section P3 and section T1b, T1c, T1d):
Ordered therapies T1B is checked **AND**
In the first 15 days from admission:
75 or more minutes are expected, T1d **AND**
rehabilitation services expected on 5 or more days, T1c **AND**
2 or more nursing rehabilitation services* received for at least 15 minutes each with each administered for 2 or more days, P3.

***Nursing Rehabilitation Services***

| | |
|---|---|
| ***H3a,b**** | ***Any scheduled toileting program and/or bladder retraining program*** |
| ***P3a,b**** | ***Passive and/or active ROM*** |
| ***P3c*** | ***Splint or brace assistance*** |
| ***P3d,f**** | ***Bed mobility and/or walking training*** |
| ***P3e*** | ***Transfer training*** |
| ***P3g*** | ***Dressing or grooming training*** |
| ***P3h*** | ***Eating or swallowing training*** |
| ***P3i*** | ***Amputation/Prosthesis care*** |
| ***P3j*** | ***Communication training*** |

***Count as one service even if both provided***

| ***RUG-III ADL Score*** | ***RUG-III Class*** |
|---|---|
| 14-18 | RLB |
| 4-13 | RLA |

**RUG-III Classification** _____

**If the resident does not classify in the Rehabilitation Category, *proceed to Category II*.**